Medicare Program; FY 2021 Inpatient Psychiatric Facilities Prospective Payment System and Special Requirements for Psychiatric Hospitals
[CMS-1731-F and CMS-1744-F]
Summary of Final Rule

On August 4, 2020, the Centers for Medicare & Medicaid Services (CMS) published in the *Federal Register* (85 FR 47042) a final rule to update the payment rates under the Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) for fiscal year (FY) 2021. IPFs include psychiatric hospitals and excluded psychiatric units of acute hospital or critical access hospitals. Updates to the market basket and payment adjustments for the FY 2021 IPF PPS are described; notably the final rule modifies the IPF PPS wage index areas with a transition to mitigate the negative effects of this change. No changes are made to the IPF Quality Reporting (IPFQR) Program.

The final rule also modifies the condition of participation on "Special Medical Record Requirements for Psychiatric Hospitals" as addressed in the interim final rule with comment period issued on April 6, 2020 (85 FR 19230).

Tables summarizing the final FY 2021 IPF PPS payment rates and adjustments (Addendum A); the complete listing of ICD-10 Clinical Modification (CM) and Procedure Coding System codes (ICD-10-CM/PCS) (Addendum B) are not included in the final rule but are available online at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/tools. The FY 2021 wage index tables will be made available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/WageIndex.

TABLE OF CONTENTS

I. Background

Under the IPF PPS facilities are paid based on a standardized federal per diem base rate adjusted by a series of patient-level and facility-level adjustments as applicable to the IPF stay. The final rule reviews in detail the statutory basis and regulatory history of the IPF PPS; the system was implemented in January 2005 and was put on a federal FY updating cycle beginning with FY 2013.

The base payment rate was initially based on the national average daily IPF costs in 2002 updated for inflation and adjusted for budget neutrality. The initial standardized budget-neutral federal per diem base rate established for cost reporting periods beginning on or after January 1, 2005 was $575.95, and has been updated based on statutory requirements in annual notices or rulemaking since then. Additional payment policies apply for outlier cases, interrupted stays, and a per treatment payment for patients who undergo electroconvulsive therapy (ECT). The ECT per treatment payment rate is also subject to annual updates.

CMS continues to use payment adjustment factors for the IPF PPS that were established in 2005 and derived from a regression analysis of the FY 2002 Medicare Provider and Analysis Review (MedPAR) data file (69 FR 66935- 66936). The patient-level adjustments address age, Diagnosis-Related Group (DRG) assignment, and comorbidities; higher per diem costs at the beginning of a patient's stay and lower costs for later days of the stay. Facility-level adjustments involve the area wage index, rural location, teaching status, a cost-of-living adjustment for IPFs located in Alaska and Hawaii, and an adjustment for the presence of a qualifying emergency department (ED).

In order to bill for ECT services IPFs must include a valid procedure code; CMS reports that no changes were made to the ECT procedure codes as a result of the update to the ICD-10-PCS code set for FY 2021. (The ECT procedure codes for FY 2021 are included in Addendum B; link provided on page 1 of this summary.)

Regulations pertaining to the IPF PPS are found in Subpart N of 42 CFR Part 412.

II. Provisions of the FY 2021 IPF Final Rule

A. Market Basket Update

In the FY 2020 final rule (84 FR 38426-38447), a rebased market basket was adopted using 2016 Medicare cost report data for both freestanding psychiatric hospitals and psychiatric units. For FY 2021, CMS updates that 2016-based IPF market basket to reflect projected price increases according to the IHS Global Inc.'s (IGI) second quarter 2020 forecast with historical data through the first quarter of 2020. Using that forecast the 2016-based IPF market basket increase factor for FY 2021 is 2.2 percent, substantially below the proposed rule projection of 3.0 percent. CMS notes that the lower forecast is primarily due to slower anticipated compensation growth for both health-related and other occupations, as labor markets are expected to be significantly impacted during the recession that began in February 2020.

The applicable multifactor productivity (MFP) adjustment is finalized to equal 0.0 percent, a notable change from the -0.4 percent anticipated in the proposed rule. By statute, the IPF PPS uses the MFP adjustment that applies to the Inpatient Prospective Payment System (IPPS) for acute care hospitals. For the final rule, CMS uses the most recent available forecast for the 10-year moving average of changes in MFP for the period ending September 30, 2021. That forecast, from June 2020, is -0.1, which if subtracted from the market basket would result in a +0.1 percentage point addition to the IPF update factor. The statute does not allow for a positive MFP adjustment; therefore the final rule includes an adjustment of 0.0 percentage points. CMS notes that it is not using IGI's second quarter 2020 MFP forecast, which is usually would do for the final rule MFP as well as for the market basket forecast. That forecast would have resulted in an MFP adjustment for FY 2021 of -0.7 percentage points. The large difference in the second quarter and June MFP forecasts is atypical and due to the unprecedented economic uncertainty associated with the COVID-19 pandemic. (The MFP forecasts are available monthly, whereas the market basket forecast is only updated quarterly. The most recent market basket forecast available for the final rule is the second quarter 2020 forecast.)

Therefore, the final FY 2021 IPF PPS payment rate update is 2.2 percent (2.2 – 0.0 = 2.2). For facilities that fail to meet requirements of the IPFQR Program for a fiscal year, the statute requires a reduction in the update factor that would otherwise apply of 2.0 percentage points. For FY 2021, the update factor for these facilities will be 0.2 percent (2.2– 2.0 – 0.0 = 0.2).

B. Labor-Related Share

The area wage index adjustment is applied to the labor-related share of the standardized federal per diem base rate. The labor-related share is the national average portion of costs related to, influenced by, or varying with the local labor market, and is determined by summing the relative importance of labor-related cost categories included in the 2016-based market basket.[1]

For FY 2021, the final labor-related share based on IGI's second quarter 2020 forecast of the 2016-based IPF PPS market basket is 77.3 percent, a change from 76.9 percent for FY 2020. Table 1 in the final rule compares the labor-related shares for FYs 2020 and 2021 by component.

C. FY 2021 Payment Rates

CMS determines the FY 2021 final payment rates by applying the market basket update factor (2.2 percent), the MFP (0.0 percent), and the wage index budget neutrality adjustment (0.9989, as discussed in section II.E.3 below) to the final FY 2020 rates. As noted above, the update factor will be reduced by 2.0 percentage points for facilities that fail to meet the requirements of the IPFQR Program for FY 2021.

[1] The labor-related market basket cost categories are Wages and Salaries; Employee Benefits; Professional Fees: Labor-Related; Administrative and Facilities Support Services; Installation, Maintenance, and Repair; All Other: Labor-related Services; and a portion (46 percent) of the Capital-Related cost weight. The relative importance reflects the different rates of price change for these cost categories between the base year (FY 2016) and FY 2021.

The table below compares the final federal per diem base rate and the ECT payments per treatment for FYs 2021 and 2020. (The 2020 amounts are taken from Addendum A to the FY 2020 IFP PPS final rule.)

	Final FY 2020*	**Final FY 2021**
Federal per diem base rate	$798.55	$815.22
Labor share	*$614.08 (76.9%)*	*$630.17 (77.3%)*
Non-labor share	*$184.47 (23.1%)*	*$185.05 (22.7%)*
ECT payment per treatment	$343.79	$350.97
*Rates for IPFs that fail to meet the IPFQR Program requirements***		
Per diem base rate	$782.85	$799.27
Labor share	*$602.01 (76.9%)*	*$617.84 (77.3%)*
Non-labor share	*$180.84 (23.1%)*	*$181.43 (22.7%)*
ECT payment per treatment	$337.03	$344.10
*The 2020 amounts are taken from Addendum A to the FY 2020 IFP PPS final rule, available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/tools **Note that the FY 2021 rates for hospitals failing to meet the IPFQR Program requirements are calculated by multiplying the full rates for FY 2020 times the reduced update factor and wage index budget neutrality factor.		

D. Updates to the IPF PPS Patient-Level Adjustment Factors

Payment adjustments are made for the following patient-level characteristics: Medicare Severity Diagnosis Related Groups (MS–DRGs) assignment of the patient's principal diagnosis, selected comorbidities, patient age, and variable costs during different points in the patient stay. For FY 2021, CMS continues the existing payment adjustments with some updates, described briefly here. The referenced Addendum A and Addendum B are available through the link that appears on page 1 of this summary.

1. Update to MS-DRG Assignment

For FY 2021, CMS proposes to continue the existing payment adjustment for psychiatric diagnoses that group to one of the existing 17 IPF MS-DRGs listed in Addendum A. Psychiatric principal diagnoses that do not group to one of the 17 designated MS-DRGs will still receive the federal per diem base rate and all other applicable adjustments, but the payment will not include an MS-DRG adjustment.

The diagnoses for each IPF MS-DRG will be updated as of October 1, 2020, using the final IPPS FY 2021 ICD-10-CM/PCS code sets. CMS notes that the FY 2021 IPPS final rule includes tables of the changes to the ICD-10-CM/PCS code sets which underlie the FY 2021 IPF MS-DRGs. (At the time this summary was prepared, the FY 2021 IPPS final rule had not been released.) The tables will be available on the CMS web page for the FY 2021 IPPS final rule.

CMS discusses the Code First policy which follows the ICD–10–CM Official Guidelines for Coding and Reporting, and notes that for FY 2021, there were 18 ICD-10-PCS codes deleted from the IPF Code First table, which is shown in Addendum B (link on page 1 of this summary.)

The Code First table was unchanged for FYs 2018, 2019 and 2020. Under the Code First policy, when a primary (psychiatric) diagnosis code has a ‘‘code first’’ note, the provider would follow the instructions in the ICD–10–CM text to determine the proper sequencing of codes.

2. Comorbidity Adjustment

The comorbidity adjustment provides additional payments for certain existing medical or psychiatric conditions that are secondary to the patient's principal diagnosis and are expensive to treat. Diagnoses that relate to an earlier episode of care and have no bearing on the current hospital stay are excluded and must not be reported on IPF claims. Comorbid conditions must exist at the time of admission or develop subsequently, and affect the treatment received, the length of stay, or both.

FY 2021, CMS continues the same 17 comorbidity adjustment factors in effect for FY 2020, which are found in Addendum A.

CMS has updated the ICD-10-CM/PCS codes associated with the existing IPF PPS comorbidity categories, based upon the FY 2021 update to the ICD-10-CM/PCS code set. These updates include the addition of codes to the Drug and/or Alcohol Induced Mental Disorders and Oncology comorbidity categories and the addition and deletion of codes in the Infectious Disease, Poisoning, and Renal Failure comorbidity categories. These updates are detailed in Addendum B.

Under previously adopted policy, CMS reviewed all new FY 2021 ICD-10-CM codes to remove codes that were site "unspecified" in terms of laterality from the FY 2020 ICD-10-CM/PCS codes in instances where more specific codes are available. None of the additions to the FY 2021 ICD-10-CM/PCS codes were site "unspecified" by laterality, therefore none are removed.

3. Age Adjustment

The current payment adjustments for age, which provide for increased payments ranging from an adjustment factor of 1.01 for patients age 45 to 50 to 1.17 for patients age 80 and older, are continued for FY 2021. The age adjustments are shown in Addendum A.

4. Variable Per Diem Adjustments

The variable per diem adjustments recognize higher ancillary and administrative costs that occur disproportionately in the first days after admission to an IPF and are shown in Addendum A. For FY 2021, CMS continues the FY 2020 variable per diem adjustments. The adjustment is highest on day 1 of the stay and gradually declines through day 22. The day 1 adjustment factor is 1.31 if the IPF has a qualifying ED; otherwise the adjustment factor is 1.19. For days 22 and later the adjustment is 0.92. The qualifying ED adjustment is discussed in section II.E.6 below.

E. Updates to the IPF PPS Facility-Level Adjustments

Facility-level adjustments provided under the IPF PPS are for the wage index, IPFs located in rural areas, teaching IPFs, cost of living adjustments for IPFs located in Alaska and Hawaii, and IPFs with a qualifying ED.

1. Wage index adjustment

To recognize geographic variation in wages for the IPF PPS, CMS uses the pre-floor, pre-reclassified IPPS hospital wage data to compute the IPF wage index. It believes that IPFs generally compete in the same labor market as IPPS hospitals, and that the pre-floor, pre-reclassified IPPS hospital wage index to be the best available data to use as proxy for an IPF specific wage index. As to the time frame for the wage index data, beginning with FY 2020, CMS uses the IPPS wage index for the concurrent fiscal year. For example, the FY 2020 IPF wage index is based on the FY 2020 pre-floor, pre-reclassified IPPS hospital wage Index. (Previous policy was to use the IPPS wage index data for the prior fiscal year.)

The geographic areas used for the wage index are based on the Office of Management and Budget (OMB) Core Based Statistical Area (CBSA) delineations. These are generally subject to major revisions every 10 years to reflect information from the decennial census, but OMB also issues minor revisions in the intervening years through OMB Bulletins. When OMB changes delineations that modify the IPPS wage index, these changes are also adopted for purposes of the IPF wage index. The history of these changes to the IPF wage index is discussed in the final rule. For purposes of the IPF wage index, OMB-designated Micropolitan Statistical Areas[2] are considered to be rural areas. The OMB Bulletins are available at https://www.whitehouse.gov/omb/information-for-agencies/bulletins/.

For FY 2021, CMS modifies the IPF wage index to reflect changes included in OMB Bulletin No. 18-04, issued on September 14, 2018 and to provide for a transition policy as detailed further below. CMS notes that on March 6, 2020, OMB issued OMB Bulletin 20-01, but CMS says it was not issued in time for development of the final rule. (Note that in the proposed rule, CMS stated that it does not believe that the minor updates included in Bulletin 20-01 would impact its updates to the labor market area delineations. At that time, CMS said it would include any updates from that bulletin in any changes adopted in the FY 2021 final rule.)

Adopting the revised delineations included in OMB Bulletin No 18-04 changes 34 urban counties and 5 providers from urban to rural; another 47 counties and 4 providers from rural to urban, and shifts some urban counties between existing and new CBSAs. Tables 2, 3 and 5 in the final rule detail the areas affected by these substantive changes. Table 4 identifies areas where only the CBSA name or number would change, without affecting assignment of a wage index. CMS has identified 49 IPFs that are affected by the changes in urban areas shown in Table 5.

[2] OMB defines a Micropolitan Statistical Area as an area 'associated with at least one urban cluster that has a population of at least 10,000, but less than 50,000.

CMS disagrees with commenters suggesting that the wage area delineation changes be delayed due to the COVID-19 public health emergency or because of the large impact of the changes in certain areas. It believes that implementing the changes will result in more accurate IPF wage index values, and that the transition policy will mitigate the negative effects where they occur.

Under the transition policy, a 5 percent cap will limit the decrease in any IPF's wage index from FY 2020 to FY 2021. It is applied regardless of the reason for the wage index decline, that is, whether or not the decline was the result of changes to the wage area delineations. The cap provides for what CMS refers to as a two-year transition to the new wage index areas. No cap will be applied in FY 2022.

In its comments the Medicare Payment Advisory Commission recommended that the transition cap apply to increases in the wage index as well as decreases. CMS disagrees and states that the purpose of the cap is to mitigate the negative effects of changing the wage area delineations, not to curtail the positive effects.

2. Adjustment for Rural Location

CMS continues the 17 percent adjustment for IPFs located in a rural area that has been part of the IPF PPS since its inception.

3. Wage Index Budget Neutrality Adjustment

Changes to the IPF PPS wage index are made in a budget neutral manner; CMS estimates the budget neutrality adjustment for FY 2021 to be 0.9989. To make this calculation, CMS estimates aggregate IPF PPS payments using the FY 2020 labor-related share and wage index values and the FY 2019 IPF PPS claims data and then estimates aggregate payments using the final FY 2021 labor share and wage index values and the same utilization data. The ratio of the amount based on the FY 2020 index to the amount estimated using the 2021 index is the budget neutrality adjustment to be applied to the federal per diem base rate for FY 2021.

4. Teaching Adjustment

CMS continues for FY 2021 the coefficient value of 0.5150 for the teaching adjustment to recognize the higher indirect operating costs experienced by hospitals that participate in graduate medical education programs. The teaching adjustment formula follows, where ADC = average daily census.

$$1 + \left(\frac{\text{IIIIIIIIIIIII aaIIaa RRIIIIRRaaIIIIIIII}}{\text{AAAAAA}}\right)^{0.5150}$$

For example, the teaching adjustment for an IPF with a ratio of interns and residents to ADC of 0.2 equals 1.098. This adjustment is applied to the federal per diem base rate.

5. Cost of Living Adjustment for Alaska and Hawaii

The IPF PPS cost of living adjustment (COLA) factors for Alaska and Hawaii in FY 2021 are unchanged from FY 2020, and are shown in Addendum A. The adjustment is 1.25 for all areas except the county of Hawaii, for which the adjustment is 1.21.

6. Adjustment for IPFs with a Qualifying ED

The IPF PPS includes a facility-level adjustment for IPFs with qualifying EDs, which is applied through the variable per diem adjustment described in section II.D.4 above. The adjustment applies to a psychiatric hospital with a qualifying ED or an IPPS-excluded psychiatric unit of an IPPS hospital or critical access hospital (CAH), and is intended to account for the costs of maintaining a full-service ED. This includes costs of preadmission services otherwise payable under the Medicare Hospital Outpatient Prospective Payment System that are furnished to a beneficiary on the date of the beneficiary's admission to the hospital and during the day immediately preceding the date of admission to the IPF, and the overhead cost of maintaining the ED.

As described in section II.D.4 above, the ED adjustment is incorporated into the variable per diem adjustment for the first day of each stay. Those IPFs with a qualifying ED receive a variable per diem adjustment factor of 1.31 for day 1; IPFs that do not have a qualifying ED receive a first-day variable per diem adjustment factor of 1.19.

With one exception, this facility-level adjustment applies to all admissions to an IPF with a qualifying ED, regardless of whether the patient receives preadmission services in the hospital's ED. The exception is for cases when a patient is discharged from an IPPS hospital or CAH and admitted to the same IPPS hospital's or CAH's excluded psychiatric unit. The adjustment is not made in this case because the costs associated with ED services are reflected in the DRG payment to the IPPS hospital or through the reasonable cost payment made to the CAH. In these cases, the IPF receives the day 1 variable per diem adjustment of 1.19.

F. Other Payment Adjustments and Policies

The IPF PPS provides for outlier payments when an IPF's estimated total cost for a case exceeds a fixed dollar loss threshold amount (multiplied by the IPF's facility-level adjustments) plus the federal per diem payment amount for the case. For qualifying cases, the outlier payment equals 80 percent of the difference between the estimated cost for the case and the adjusted threshold amount for days 1 through 9 of the stay, and 60 percent of the difference for day 10 and thereafter. The differential in payment between days 1 through 9 and 10 and above is intended to avoid incenting longer lengths of stay.

For FY 2021, CMS continues to set the fixed dollar loss threshold amount at a level such that outlier payments account for 2 percent of total payments made under the IPF PPS. Based on an analysis of the latest available data (the March 2020 update of FY 2019 IPF claims) and rate increases, CMS estimates that for FY 2020 IPF outlier payments will be 1.9 percent of total

payments. Therefore, for FY 2021, CMS decreases the outlier threshold amount to $14,630 from the FY 2020 level of $14,960 in order to maintain estimated outlier payments at 2 percent of estimated aggregate IPF PPS payments.

In estimating the total cost of a case for comparison to the outlier threshold amount, CMS substitutes the national median urban or rural CCR if the IPF's CCR exceeds a ceiling that is equal to the 3 times the standard deviation from the appropriate (i.e., urban or rural) geometric mean CCR. The national median also applies to new IPFs and those for which the data are inaccurate or incomplete. CMS updates these amounts for FY 2021 as shown in the table below, which also appears in Addendum A.

National Median and Ceiling Cost-to-Charge Ratios (CCRs)		
CCRs	**Rural**	**Urban**
National Median	0.5720	0.4200
National Ceiling	2.0082	1.7131

III. Update on IPF PPS Refinements

As noted earlier, the IPF PPS adjustments are based on analyses conducted when the program was implemented for 2005, based on MedPAR data from FY 2002. CMS has previously determined that it would make refinements to the IPF PPS once it has completed a thorough analysis of IPF PPS data that include as much information as possible regarding the patient-level characteristics of the population that each IPF serves. It has begun and will continue these analyses with the intention of refining the IPF PPS adjustments in the future, as appropriate. CMS reviews concerns about variation in IPF cost and claims data, particularly related to labor costs, drugs costs, and laboratory services, and its efforts to improve IPF cost reports with respect to ancillary costs.

IV. Special Requirements for Psychiatric Hospitals (§482.61(d))

CMS responds to comments on and finalizes a provision pertaining to the conditions of participation (CoP) on "Special Medical Record Requirements for Psychiatric Hospitals" that was included in the interim final rule with comment pertaining to the COVID-19 public health emergency issued on April 6, 2020 (85 FR 19230). Specifically, the provision changes the requirements under §482.61(d) pertaining to recording patient progress notes to delete a reference[3] to and to remove the word "independent" from the phrase "licensed independent practitioner" when referencing nonphysician practitioners. The latter change is consistent with revisions previously made to the regulations at §482.13.

[3] The reference was to §482.12(c), which lists the types of physicians that the hospital must ensure that every Medicare patient is under the care of, such as a doctor of medicine or osteopathy. CMS has removed this reference in other provisions, because with a few exceptions, the CoPs apply to all patients, regardless of payment source, and not just Medicare beneficiaries.

CMS discusses the benefits of advanced practice providers (APPs), which includes physician assistants, nurse practitioners, psychologists, and clinical nurse specialists as well as other qualified, licensed practitioners. It believes that APPs should have the authority to practice more broadly and to the highest level of their education, training, and qualifications as allowed under their respective state requirements and laws. Additionally, CMS believes that non-physician practitioners practicing in psychiatric hospitals should be able to record progress notes of psychiatric patients for whom they are responsible. Therefore, it now allows the use of APPs to document progress notes of patients receiving services in psychiatric hospitals, in addition to medical doctors and doctors of osteopathy, as previously required.

In addition, CMS believes that using the term "licensed independent practitioner" may inadvertently exacerbate workforce shortage concerns, and unnecessarily restrict a hospital's ability to allow APPs and other non-physician practitioners to operate within the scope of practice allowed by state law. Further, CMS believes that patient care might benefit from full use of APPs and their clinical skills as allowed by hospital policy in accordance with state law.

Commenters were generally supportive of the change. Responding to one, CMS says that it will review the CoPs with respect to provider types in addition to APPs. It disagrees with a suggestion that the changes be effective only during the COVID-19 public health emergency and defers to state law and hospital policy with respect to the requirement of general supervision of APPs by physicians.

In the regulatory impact analysis section of the final rule, CMS estimates that allowing APPs to record patient progress notes will result in savings to psychiatric hospitals of $177 million annually. CMS notes the difficulty in attributing these savings across the several rules that address this progress note recording requirement.

V. Waiver of the 60-Day Delayed Effective Date for the Final Rule

The final rule is effective with the beginning of the FY 2021, on October 1, 2020. Normally, CMS publishes a final rule at least 60 days prior to its effective date, in accordance with the Congressional Review Act (CRA). In the case of this FY 2021 IPF PPS final rule, CMS is using its authority under the CRA to waive this requirement because its work on COVID-19 delayed the issuance of the final rule. CMS believes it would be contrary to the public interest to do otherwise. CMS notes that it is providing a 30-day delay in accordance with the Administrative Procedures Act (5 U.S.C. 553(d)) and section 1871(e)(1)(B)(i) of the Social Security Act, which generally prohibits a substantive rule from taking effect before the end of the 30-day period beginning on the date of its public availability.

V. Regulatory Impact Analysis

CMS estimates that payments to IPF providers for FY 2021 will increase by $95 million under the final rule. This reflects a $90 million increase from the 2.2 percent update to the payment rates as well as a $5 million increase as a result of the updated outlier threshold amount. As discussed above, outlier payments are estimated to change from 1.9 percent in FY 2020 to 2.0

percent of total estimated IPF payments in FY 2021. Not included in this estimate are any reduced payments associated with the required 2.0 percentage point reduction to the market basket increase factor for any IPF that fails to meet the IPFQR Program requirements.

As discussed earlier, the estimated effects of the change in the CoPs for psychiatric hospitals with respect to allowing nonphysician practitioners to document patient progress notes totals $177 million annually. CMS notes the difficulty in attributing these savings across the several rules that address this progress note recording requirement.

Table 7 in the final rule, reproduced below, shows the estimated effects of the IPF PPS final rule policies by type of IPF.

TABLE 7: FY 2021 IPF PPS Payment Impacts
[Percent Change in Columns 3 through 6]

Facility by Type	Number of Facilities	Outlier	Wage Index FY21	Wage Index FY21 New CBSA and 5% Loss Cap	Total Percent Change[1]
(1)	(2)	(3)	(4)	(5)	(6)
All Facilities	1,550	0.1	0.0	0.0	2.3
Total Urban	1,241	0.1	0.0	0.0	2.3
Urban unit	755	0.1	0.0	0.1	2.4
Urban hospital	486	0.0	0.0	-0.1	2.2
Total Rural	309	0.0	-0.1	-0.1	2.0
Rural unit	248	0.0	-0.2	-0.2	1.9
Rural hospital	61	0.0	0.0	0.0	2.2
By Type of Ownership:					
Freestanding IPFs					
Urban Psychiatric Hospitals					
Government	118	0.1	0.3	0.1	2.7
Non-Profit	96	0.0	0.1	-0.1	2.2
For-Profit	272	0.0	0.0	-0.1	2.1
Rural Psychiatric Hospitals					
Government	31	0.0	0.0	0.0	2.2
Non-Profit	12	0.0	0.2	-0.1	2.4
For-Profit	18	0.0	0.0	0.0	2.2
IPF Units					
Urban					
Government	112	0.1	0.1	0.3	2.8
Non-Profit	492	0.1	0.0	0.1	2.4
For-Profit	151	0.0	-0.1	-0.1	2.1
Rural					
Government	63	0.0	-0.3	-0.1	1.8
Non-Profit	136	0.1	0.0	-0.2	2.1
For-Profit	49	0.0	-0.4	-0.2	1.7

Facility by Type	Number of Facilities	Outlier	Wage Index FY21	Wage Index FY21 New CBSA and 5% Loss Cap	Total Percent Change[1]
By Teaching Status:					
Non-teaching	1,357	0.0	0.0	-0.1	2.1
Less than 10% interns and residents to beds	108	0.1	0.2	0.5	2.9
10% to 30% interns and residents to beds	65	0.1	0.1	0.2	2.7
More than 30% interns and residents to beds	20	0.2	0.4	0.0	2.7
By Region:					
New England	106	0.1	-0.9	-0.1	1.3
Mid-Atlantic	218	0.1	0.7	0.4	3.5
South Atlantic	243	0.0	0.0	0.0	2.2
East North Central	255	0.0	0.0	-0.1	2.2
East South Central	155	0.0	0.0	-0.1	2.1
West North Central	114	0.1	-0.6	0.0	1.6
West South Central	227	0.0	0.0	-0.1	2.1
Mountain	105	0.0	-0.6	-0.1	1.5
Pacific	127	0.1	0.3	-0.1	2.6
By Bed Size:					
Psychiatric Hospitals					
Beds: 0-24	87	0.0	0.1	0.0	2.3
Beds: 25-49	83	0.0	0.2	-0.1	2.3
Beds: 50-75	86	0.0	-0.3	-0.1	1.8
Beds: 76 +	291	0.0	0.1	-0.1	2.2
Psychiatric Units					
Beds: 0-24	561	0.1	-0.1	0.0	2.1
Beds: 25-49	260	0.1	-0.1	-0.1	2.1
Beds: 50-75	115	0.1	0.0	0.1	2.4
Beds: 76 +	67	0.1	0.4	0.6	3.3

[1] This column includes the impact of the updates in columns (3) through (5) above, and of the IPF market basket increase factor for FY 2021 (2.2 percent), reduced by 0 percentage point for the productivity adjustment as required by section 1886(s)(2)(A)(i) of the Act.